

the submaxillary gland, angio-sarcomata and endotheliomata; one tumor of the ascending ramus of the lower jaw, under the normal mucous membrane; two of the lower lip, and one under the skin of the eye-brows, all of which by their histological structure, formation and relation to their surroundings, are to be placed on the same level as the parotid tumors. These so-called mixed tumors, as a rule, are but loosely connected with the glandular tissue and hence are more easily extirpated. They are by far more frequent than the epithelial forms. The epithelioid cells found under the forms of fibres, cylinders and glandular tubes are probably all of endothelial origin. As these tumors may also appear on other portions of the face, and bear no relation to the parotid gland, it is possible that they have nothing to do with the glandular tissue and are to be regarded as springing from the endothelium. Finally, six tumors of the soft parts of the face and head are described, some of which were probably, and others were certainly, of epithelial origin, and, with the exception of one, were regarded as benign, with their point of departure in the cutaneous glands or hair sacs. — *Archiv für klinische Chirurgie*, Bd. XLIV.

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#### BONES—JOINTS—ORTHOPÆDIC.

##### I. Treatment of Recent Fractures of the Patella.

By Dr. W. KÖRTE (Berlin). After reporting a number of cases of fracture of the patella treated in the Urban City Hospital, in Berlin, the surgical director, Körte, sums up his conclusions as follows:

Fractures of the patella, with a moderate degree of separation of the fragments, 2 cm., and with not much hæmorrhage into the joint, are best treated by massage and early passive motion. Fractures with pronounced hæmorrhage and a still greater degree of separation should be treated by puncture of the joint and the application of the tendon suture, as recommended by Volkmann. After emptying the joint, a well-curved needle is used to pass a heavy silver wire through the ligamentum patellæ close to the lower margin

of the bone; another similar wire is passed through the quadriceps tendon at its insertion. These two wires are twisted together over an iodoform gauze cushion lying upon the skin over the patella. This procedure he regards as free from danger, as the wire does not penetrate the joint sac.

Bone suturing is to be employed only in cases of compound fracture, where it is always indicated if there is a marked degree of separation; also in old fractures with great loss of function, if the muscle is still in good condition. It is also indicated in cases of refracture occurring soon after the parts have healed, and where an imperfect reunion of the torn ligamentous structures is feared.—*Deutsche medicinische Wochenschrift*, July 13, 1893.

It may be remarked that in the resumé which a surgeon appends to his article on the treatment of fractures of the patella, we have an index to the degree of asepsis which he, in his particular clinic, is able to command.

JAMES P. WARBASSE (Brooklyn).

**II. Spina Bifida.**—By DR. HILDEBRAND (Göttingen). Dr. Hildebrand has made a study of twenty-seven cases of spina bifida. The worst form of this disease which he has observed is that in which all of the posterior structures are cleft—bone, dura, pia, cord and the overlying soft parts. In these cases, as a result of hydrops, a myelocoele develops, in which the pia is protruded backward in the form of a sac, so that the inner surface of the pia becomes the outer surface of the sac. Upon this lies the cord as the area medullo-vasculosa. At the place where the spinal cord is inserted within is observed a depression in the sac.

The next form which he describes is that in which the cord, pia, and arachnoid remain closed, but the dura and bone are cleft. In these cases, when the hydrops is in the cord, myelocystocoele results; when it is between pia and arachnoid, meningocele occurs. The last form is that in which the cord, pia, arachnoid and dura are closed; only the bone being cleft. In this either dura and arachnoid form the covering of the sac, or only the dura alone; which ever is the case, the tumor is a meningocele.

The predecessors of Recklinghausen believed that in all cases of rachiochisis only the bone was cleft. Recklinghausen himself was of the opinion that the cleft involved at least the bone and the dura. Hildebrand now shows that the defect may involve the bone, the meninges or the cord, stopping anywhere from the first to the last.

Upon the ground of these anatomic differences he calls attention to the clinical appearances of the different forms and their differential diagnosis. In the unopened sac it is often difficult to distinguish between a meningocele and a myelocystocele. This fact is important because operation is indicated in as much as the knife has to be employed to make the diagnosis. The author excludes from operation cases in which there is any marked degree of paralysis, for this is irreparable. In meningocele the skin should be dissected up from the tumor as far as it is normal, and the sac of the meninges cut off on a level with the spinal column. Any adherent nerves must be protected and finally replaced. The borders of the meninges are then sutured together and the overlying skin with muscle and fascia united across the wound.

In myelocoele a lateral transverse incision must be made and the position of the nerves discovered. If they run free through the sac, the area medullo-vasculosa with the nerves should be cut about, replaced in the spinal canal, the sac cut away and its edges sewed together and the skin and fascia sewed over the wound. If the nerves are in the walls of the sac the whole sac must be replaced into the canal and the skin made to cover it. Myelocystocele he treats the same as meningocele. Small cysts need not be operated upon, because they are usually covered with normal skin. When they begin to increase in size, and the skin becomes thin, the skin should be dissected up, the tumor emptied and replaced in its bony channel, and covered with strong skin or a flap of muscle and skin. Hildebrand is of the opinion that when the hydrops has once disappeared it never recurs if normal skin is used to cover the defect. In case of large, bony defect, he recommends after König the covering with a flap of muscle and skin, or an osteoplastic operation. He reports

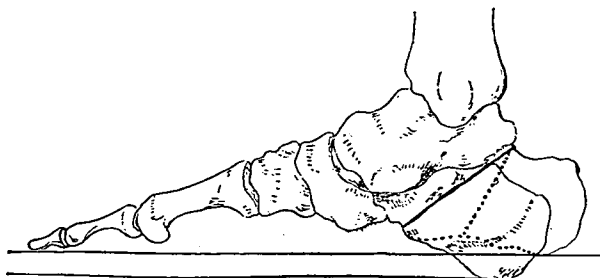
thirteen cases of spina bifida operated upon in the Göttingen clinic—ten meningocele, and three myelocystocele. Three died from the operation and ten were discharged cured. One of these latter died soon after leaving the clinic. Eight are still living and well. Two of these had myelocystocele; the third with myelocystocele had a recurrence with pronounced hydrocephalus and died three months after operation.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

**III. Resection of the Left Hip-joint and Knee-joint in a Delicate Five-year-old Child, Cured.** By Dr. A. KOEHLER (Berlin). The child had had an enlarged knee for two years, and the disease of the hip had been observed for one year. Large abscesses were found in both joints. Both hip-joint and knee-joint were resected at one sitting. Absorbent dressings without splints were applied. Secondary suture with injection of iodoform glycerin was done. In four weeks the wounds had healed with fistulæ. These became closed while the child was allowed to run about in a removable plaster dressing. At the present time, nine months after the operation, the child is well, and runs about the whole day long.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

**IV. Displacement of the Semilunar Cartilages and its Operative Treatment.** By Dr. BORCK (Rostock). Borck reports a case of internal knee lesion belonging to a very rare class, a case with complete tearing across of the cartilage in its substance, that is, with separation of the front from the hinder point of attachment. The patient fell from his horse, striking upon the right foot with the knee bent, and then fell backward to the ground. He complained at once of very severe pain on the inside of the joint. A considerable amount of hæmorrhage took place in the joint. He often felt a body about half the size of a silver dime near the inner border of the patellar ligament, which returned into the joint on the

least pressure. Three months after the accident Borck opened the joint on its inner side. A small amount of clear synovial fluid escaped. On abducting the leg a small body appeared which belonged to the inner meniscus. The anterior third of this cartilage had been separated from its peripheral attachments, and was attached only by its anterior extremity. The operator removed the loose piece of cartilage, and closed the wound. At the end of thirty days the patient was without pain, and left the hospital cured.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

**V. The Operative Treatment of Flat-foot.** By Dr. GLEICH (Vienna). Two different views seem to predominate in the operative treatment of flat-foot; the wedge resection of the talo-navicular joint of Ogston, and the supra-malleolar osteotomy of Tren-



delenburg. Ogston seeks for the cause of the trouble in Chopart's joint, and corrects the deformity with ankylosis. Trendelenburg arrives at his conclusion through the pathological anatomical observation that supra-malleolar fractures act as a cure for flat-foot. The advantage of the latter operation is that it does no injury to the elasticity of the arch of the foot.

The author has endeavored to perfect an operation upon the skeleton of the foot, which shall correct the deformity and give rise to no ankylosis. He observed that traumatic flat-foot was due

usually to fracture of the os calcis, and from this fact obtained the key to the operation which he has invented. The operation is as follows:

The calcaneus is sawed through diagonally, somewhat steeper than the section of Günther, and the posterior fragment shoved forward about two centimetres. This lifts the foot about one centimetre, and the angle formed by the calcaneum and the fore-foot is increased. The distance which the heel can thus be shoved forward is, of course, limited; but if it is desired to still more increase the concavity of the arch, the heel can be thrown further toward the perpendicular by excising a narrow wedge instead of making a simple section through the bone. By this procedure the calcaneus is bent upon itself as it were, a condition which exists in the normal foot, but which in the flat-foot is lost. When a wedge resection is done, the effect of the operation can be increased by also shoving the heel forward and downward, as is done in the simple linear section. The technique of the operation is simple. The incision used is the same as that employed in Pirogoff's operation. The calcaneus is exposed, and the operation begun from the lower side. Tenotomy of the tendo-achillis is, of course, done first of all. If it is desired, the weight of the body can be made to come more on the outer side of the foot by carrying the heel slightly inward.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

JAMES P. WARBASSE (Brooklyn).

**VI. On the Treatment of Club-foot.** By J. PANUM (Copenhagen, Denmark). Panum, out of 148 cases of congenital deformities, found sixty-one cases of club-foot, of which thirty-six were males and twenty-five females. During the weeks immediately following labor, he employs manual reposition, and the foot is placed in a little splint. At the end of the third week a plaster-of-Paris boot is applied, under an anæsthetic; tenotomy is rarely necessary. After a few weeks the boot is renewed, until after a few months the foot is so tractable that it is easily held in position. Then the patient receives a splint applied at night and daily reposition. When

a year shall have passed, he should wear a pair of boots. If the child come under treatment at a later age, tenotomy is necessary, followed by reposition and application of a plaster boot, which is changed every three or four weeks until the foot is in its proper position; after that a boot with a stiff ankle and upper, together with a thick sole. In twelve patients Phelps' operation was done with good results, yet in a majority of them the club-foot altered to a splayed foot; only one of the patients was an adult. In extreme degrees of club-foot, as in adults, the writer is inclined to order a well-formed boot, as the results of operation upon the bones here are not encouraging, and as the majority of such patients walk quite well.—*Ugeskrift for Læger*, R. 4, Bd. XXVI, S. 503.

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#### GYNÆCOLOGICAL.

**I. The Technique of Total Extirpation of the Fibromatous Uterus.** By GEORGE M. EDERBOHLS, M.D. (New York).

Place the patient in the lithotomy position.

Thoroughly disinfect the vagina.

Disinfect the uterine cavity, as far as possible in each individual case, by means of superficial curetting and irrigation with 1-2000 sublimate solution.

Pack the uterine cavity moderately full of sublimate gauze, 1-100.

Pack the vagina *tightly* with sublimate gauze, 1-1000.

Make no vaginal incisions; do none of the cutting from below.

Now place the patient in the Trendelenburg posture.

Open the abdomen above the pubis by an incision just large enough to permit of delivery of the entire tumor.

Given a tumor weighing not above four kilogrammes, with healthy tubes and ovaries, proceed as follows:

Evertate the tumor.

Circumscribe two peritoneal flaps by two transverse incisions of the peritoneum, one on the anterior, the other on the posterior